

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028874

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 135

FILED JUL 16 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	Jasper	a. STATE	Mo. b. COUNTY Jasper
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	Carthage	c. CITY OR TOWN	Carthage
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION	McCune-Brooks hospital	d. STREET ADDRESS (If outside, give location)	Route 3
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last WILLIAM MARION CLUBB		Month Day Year July 5, 1963	
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
male	white		11-3-72 90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)
farmer		farming	Jasper Co., Mo.
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Monroe Clubb		Mary McDonald	---
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv.)		17. INFORMANT Address	
no		Belle Hartman, Rt 3, Carthage, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)			8 Days
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 6-29-63 to 7-5-63 and last saw her alive on 7-4-63 Death occurred at 7:40 a m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
[Signature] MD		Sarcoxie, Mo	7-5-63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
burial	7-8-63	Dudman Cemetery	Rt 3, Carthage, Mo
24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE	
KNELL MORTUARY, Carthage, Mo	7-8-63	[Signature]	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Frank W. Keel*

Licensed Embalmer No. 4440

P. O. Address Carthage, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.